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AUTHOR Robinson, Elizabeth; And Others
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ABSTRACT

Two major barriers which stand in the way of the delivery of psychological services to children are inadequate therapy outcome research, and the unavailability of people qualified to teach others to use developed treatments. The long distance training model was developed to avoid such problems. It includes three major components: (1) the use of highly qualified trainers with special expertise in the treatment methods being evaluated; (2) intensive workshops; and (3) continuing long distance supervision via telephone calls and mailed videotapes. To evaluate the effectiveness of the model, nine psychology graduate students were trained in one of two modes of child treatment, the Parent-Child Interaction Approach or the Social Learning Approach. Clients were 19 families with externalizing children, aged 4-7, who completed between 9 and 14 weeks of training. All sessions were videotaped and coded. Videotape analysis indicated that therapists did implement the techniques specific to their training, suggesting that the long distance model was effective in teaching the two groups of therapists. Therapists informally indicated satisfaction with their training and appreciation of the opportunity to be trained by experts. (JAC)

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LONG DISTANCE TRAINING OF CHILD THERAPISTS

Elizabeth Robinson
Carol Cole
Laura E. Feshbach
Michelle DeKlyen
University of Washington

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LONG DISTANCE TRAINING OF CHILD THERAPISTS

Elizabeth Robinson, Ph.D. Laura E. Feshbach
Carol Cole Michelle DeKlyen, M.A.
University of Washington

Despite the growing number of clinical psychologists, many groups of people still do not receive adequate psychological services. The National Institute of Mental Health has identified such groups and labeled them "underserved" populations. Among those currently underserved are children, the physically handicapped, and the aged. Two major barriers stand in the way of delivery of services to these special populations. In the first place, therapy outcome research is frequently ambiguous and full of methodological errors. These problems are exaggerated with underserved populations, where the literature is sparser and still in its infancy. Secondly, once treatments are developed, only a few people are competent to train others to use them. Frequently, these people are near the site of development and are not available for on-site supervision in other parts of the country.

Our purpose in developing the long distance training model was to avoid certain methodological errors common to therapy outcome research. The model includes three major components: 1. the use of highly qualified trainers, each with special expertise in one of the treatment methods being evaluated, 2. intensive workshops, and 3. continuing long-distance supervision via telephone calls and mailed videotapes.

O'Leary and Turkewitz (1978) delineate frequent errors in therapy outcome research. One common methodological problem is that of experimenter bias. For example, the training of therapists is often carried out by an experimenter who is more invested in one of the treatment methods and who is aware of the hypotheses being tested. In

the long distance model, training and supervision are provided by outside experts who are blind to the hypotheses of the study and who are enthusiastic about the treatments.

O'Leary and Turkewitz further note the difficulty of interpreting outcome research when what actually occurred during treatment sessions is not assessed: it cannot be determined whether the treatments being compared were implemented accurately and were, in fact, differentiable. We attempted to address this problem in three ways. First, the training was provided by experts selected by the methods' developers and thus presumably capable of accurately transmitting the treatment techniques to trainees. Second, trainees with similar backgrounds received equal amounts of training in one of the specific treatments being compared. Finally, therapy sessions were videotaped and evaluated to ensure that each therapist was actually using the appropriate techniques.

A third methodological problem in much therapy outcome research is that too few therapists are involved to allow one to make generalizations about the treatments themselves: outcome differences may be ascribed to individual therapist variables. The long distance training model offers a relatively inexpensive framework for providing high quality training to a larger number of therapists.

The training provided by the long distance model is expected to be superior to that obtained in workshops alone. Workshops usually involve short term intensive experiences, often with qualified trainers, but lack the continuing supervision and feedback which are probably necessary to establish skills and assure appropriate application and generalization. In addition to an initial three-day intensive on-site workshop and a two-day follow-up workshop several months later, the long distance model involves continuing case supervision of therapist

trainees via weekly speaker phone group supervision and the exchange of videotaped therapy sessions by mail.

Of course the details of these training procedures (e.g., frequency of supervision, length of workshops) could be modified. The critical ingredients, as noted above, are the qualifications of the outside experts, the workshop training, and the continued supervision.

Is it possible without local supervision to train and supervise therapists to effectively use a given therapeutic approach? The purpose of this paper is to evaluate the effectiveness of the long distance training model by examining whether or not therapists used techniques that were specific to particular treatment models in which they had been trained. We will first briefly describe the treatment models being compared, then present the design of the study, and finally discuss the results.

Treatment Models

In this project therapists were trained in two modes of child treatment, the Parent-Child Interaction approach developed by Constance Hanf and modified by Sheila Eyberg at the University of Oregon, and the Social Learning approach as developed by Gerald Patterson at the Oregon Social Learning Center. Both interventions are behavioral approaches to child treatment, designed to be used with acting out or externalizing children. As noted above, children are an underserved population; further, externalizing problems characterize the majority of children seen by clinicians. Both therapy modes studied teach parents to attend to and reward desirable behavior and to ignore or give contingent negative consequences for undesirable behaviors. However, they differ in the specific techniques used. A brief overview of the two treatment

programs follows.

The Social Learning Model

The first step in the social learning model is to teach parents to "pinpoint" (operationally define) specific desirable and undesirable behaviors. Next, the parents "track" (write down) each time the child engages in an undesirable behavior or its prosocial opposite (e.g., doesn't mind parent or complies with request). They then set up point charts so that the child earns points for engaging in specific positive behaviors. Parents are instructed to give a reward when the child reaches a criterion score on the point chart. When the child behaves in specified undesirable ways, parents are taught to use "time out" (time away from attention and stimulation). The child is sent to an unstimulating room, usually the bathroom, and privileges are taken away if the child refuses to go. The therapist also teaches parents to adapt the techniques to other settings and other children.

Parent-Child Interaction Approach

This model has two components: child-directed interaction (CDI) and parent-directed interaction (PDI). During CDI, the child directs the play; the parent is taught techniques such as attending to and praising appropriate behavior, ignoring inappropriate behavior, and refraining from asking questions, giving commands, or criticizing the child. The parent then practices while playing with the child, and the therapist coaches, via a "bug in the ear" device, from behind a one-way mirror. Once parents have mastered CDI they progress to PDI, during which they are taught how to give clear, direct commands and how to follow through with time out for noncompliance. In this model, the child sits in a

chair for time out, and a controlled spank is used as a back-up.

Procedures

Nine psychology graduate students were trained in one of the two approaches, using the long distance training model. Nineteen families with 4 to 7 year old externalizing children completed between nine and fourteen weeks of parent training. (Further details of the outcome study will be reported elsewhere.) All therapy sessions were videotaped and a random sample of six 10-minute segments per case (one 10-minute segment from each of six randomly selected sessions) were coded using the Therapy Process Coding System (Robinson & Love, 1982).

Results

Videotape analyses indicate that therapists did implement the techniques specific to their training (See Table I). Parent-Child Interaction therapists spent more time teaching the skills involved in CDI (attending and ignoring, $p<.002$; praise, $p<.002$) than did therapists of the Social Learning Model. The Social Learning therapists spent more therapy time on home-based point charts ($p<.002$), pinpointing specific target behaviors ($p<.01$), and discussing other client problems ($p<.05$) than did the Parent-Child Interaction therapists. Also, therapists spent more time teaching parents the time-out procedures specific to their conditions ($p<.05$). The two groups also differed in mode of presentation: the Parent-Child Interaction group spent more time in coaching ($p<.002$) and practicing ($p<.01$) and the Social Learning therapists spent more in discussion ($p<.002$). Therapists using the Parent-Child Interaction model were more likely to focus on current behavior ($p<.05$) and less likely to focus on future behavior ($p<.01$) than were therapists of the Social Learning model. It appears,

therefore, that the long distance model was effective in teaching the two groups of therapists to reliably use the specific therapy techiniques in which they were trained.

A question which we have only addressed informally is trainee satisfaction. While we have no hard data to support this, the therapists involved in this project have all informally indicated satisfaction with their training and appreciation of the opportunity to be supervised by the expert therapists.

Discussion

Our findings indicate that relatively novice therapists can be effectively trained to implement specific parent training programs through the long distance training model. While our primary purpose was to provide high quality independent training for therapy outcome research, this study also suggests a possible solution to the problem of providing appropriate training in treatments for specialized populations. We envision at least three applications of the long distance model. First, as we have proposed, researchers who wish to evaluate a particular treatment may find that the long distance training model solves certain methodological problems. Secondly, individual professionals, who often have few alternatives for learning particular therapeutic techniques (e.g., books, workshops, or leaving their practices to train with an expert), may attend workshops and then receive continuing supervision through videotapes and telephone calls after returning home. Finally, this training model suggests a relatively inexpensive means of disseminating interventions developed for particular underserved populations to therapists in geographically distant areas. An agency could arrange for clinicians from all over the

country to congregate for an intensive workshop and then provide for weekly supervision of these professionals by the expert trainer.

Future research should compare the effectiveness of the long distance training model with intensive workshop training alone and with on-site training and supervision from less expert trainers. Our experience suggests that it is possible with the long distance training model to replicate particular treatment models and to provide a satisfying training experience for trainees. Long distance training may, therefore, prove an effective solution to some of the current barriers to training and research in the treatment of underserved populations.

Reference

O'Leary, K. D., & Turkewitz, H. Methodological Errors in Marital and Child Treatment Research. Journal of Consulting and Clinical Psychology, 1978, 46, 747-758.

TABLE I

Differences Between Groups On Content, Mode, and Time Orientation

	Parent-Child Interaction Therapists	Social Learning Therapists	
Therapy Content	Minutes $\bar{X}$	Minutes $\bar{X}$	p
Attending/ignoring skills	12.38	.72	<.01
Praise	19.88	4.09	<.002
Commands	4.75	1.09	NS
Point charts	1.50	13.27	<.002
Time out: type 1	0	1.82	<.01
Time out: type 2	3.87	0	<.02
Time out: type 3	1.63	4.45	<.05
General client-centered talk	12.38	23.91	<.05
Other problem-oriented talk	.13	4.73	<.02
Irrelevant talk	.13	1.82	<.05
Therapy Mode			
Coaching	18.13	0	<.002
Practice	10.38	0	<.01
Modeling	2.63	4.00	NS
Discussion	20.86	49.82	<.002
Didactic	2.63	1.63	NS
Time Orientation			
Past	5.63	11.11	NS
Present	47.38	33.45	<.05
Future	.88	9.82	<.01

n=19 families, 9 therapists

Note: Data were collected using the Therapy Process Coding System (Robinson & Love, 1982). Scores represent the average amount of time spent per family, per therapy hour. Some minor categories are not included in this table because they occurred so infrequently; consequently, columns do not sum to 60 minutes.